FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0033969

Facility Name: Manorcare at South Holland

Address: 2145 E. 170th St. (Number) South Holland (City) 60473 (Zip Code)

County: Cook

Telephone Number: (708)895-3255 **Fax #** (708)895-3315

IDPA ID Number: 520886946014

Date of Initial License for Current Owners: 12/01/88

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Gary Geise **Telephone Number:** (419) 252-5731

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/03 to 05/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Barry A. Lazarus

(Title) Vice President, Reimbursement

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Manorcare at South Holland # 0033969 Report Period Beginning: 06/01/03 Ending: 05/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	160	Skilled (SNF)	160	58,560	1
2		Skilled Pediatric (SNF/PED)			2
3	30	Intermediate (ICF)	30	10,980	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	190	TOTALS	190	69,540	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,488	6,969	25,896	48,353	8
9	SNF/PED					9
10	ICF	12,114	3,361	1,912	17,387	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,602	10,330	27,808	65,740	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.54%

D. How many bed-hold days during this year were paid by Public Aid?
62 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/01/88

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 140 and days of care provided 18,655

Medicare Intermediary CareFirst of Maryland, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12/31/04 Fiscal Year: 05/31/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Manorcare at South Holland # 0033969 Report Period Beginning: 06/01/03 Ending: 05/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	363,187	30,451	3,968	397,606	3,477	401,083		401,083			1
2	Food Purchase		247,960		247,960		247,960	(772)	247,188			2
3	Housekeeping	180,397	22,025	3,383	205,805		205,805		205,805			3
4	Laundry	56,139	21,213	33	77,385		77,385		77,385			4
5	Heat and Other Utilities			170,577	170,577	12,671	183,248		183,248			5
6	Maintenance	66,194	29,721	134,456	230,371		230,371		230,371			6
7	Other (specify):* Medical Waste			2,514	2,514		2,514		2,514			7
8	**TOTAL General Services**	665,917	351,370	314,931	1,332,218	16,148	1,348,366	(772)	1,347,594			8
	B. Health Care and Programs											
9	Medical Director			15,000	15,000		15,000		15,000			9
10	Nursing and Medical Records	3,312,931	345,702	49,728	3,708,361	100,172	3,808,533		3,808,533			10
10a	Therapy	799,104	14,428	176,718	990,250		990,250		990,250			10a
11	Activities	107,503	5,240	5,498	118,241		118,241		118,241			11
12	Social Services	63,751	571	47	64,369		64,369		64,369			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,283,289	365,941	246,991	4,896,221	100,172	4,996,393		4,996,393			16
	C. General Administration											
17	Administrative	164,318		715,473	879,791	(327,405)	552,386		552,386			17
18	Directors Fees											18
19	Professional Services			65,792	65,792	(27,019)	38,773	(38,773)				19
20	Dues, Fees, Subscriptions & Promotions			123,429	123,429		123,429	(49,460)	73,969			20
21	Clerical & General Office Expenses	470,199	77,215	132,849	680,263	1,597	681,860	(92,803)	589,057			21
22	Employee Benefits & Payroll Taxes			906,573	906,573	84,319	990,892		990,892			22
23	Inservice Training & Education			3,393	3,393		3,393		3,393			23
24	Travel and Seminar			8,072	8,072		8,072		8,072			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			225,432	225,432		225,432		225,432			26
27	Other (specify):* Purchase Service Admin.											27
28	**TOTAL General Administration**	634,517	77,215	2,181,013	2,892,745	(268,508)	2,624,237	(181,036)	2,443,201			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,583,723	794,526	2,742,935	9,121,184	(152,188)	8,968,996	(181,808)	8,787,188			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Manorcare at South Holland #0033969 Report Period Beginning: 06/01/03 Ending: 05/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			444,925	444,925	45,693	490,618		490,618			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(52)	(52)	106,495	106,443		106,443			32
33	Real Estate Taxes			561,799	561,799		561,799		561,799			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			113,767	113,767		113,767		113,767			35
36	Other (specify):* G/L Assets											36
37	**TOTAL Ownership**			1,120,439	1,120,439	152,188	1,272,627		1,272,627			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,472	1,472		1,472		1,472			38
39	Ancillary Service Centers		516,901		516,901		516,901		516,901			39
40	Barber and Beauty Shops		79	19,616	19,695		19,695		19,695			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			104,310	104,310		104,310		104,310			42
43	Other (specify):* IV Therapy, Lab, & X-ray		145,538	136,012	281,550		281,550		281,550			43
44	**TOTAL Special Cost Centers**		662,518	261,410	923,928		923,928		923,928			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,583,723	1,457,044	4,124,784	11,165,551		11,165,551	(181,808)	10,983,743			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Manorcare at South Holland # 0033969 Report Period Beginning: 06/01/03 Ending: 05/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$	10	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(772)	2		4
5	Telephone, TV & Radio in Resident Rooms		21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds		21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(720)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(180)	21		18
19	Entertainment				19
20	Contributions	(431)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(38,773)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(80,590)	21		24
25	Fund Raising, Advertising and Promotional	(49,460)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Vending & Misc. Income	(10,882)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (181,808)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (181,808)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Manorcare at South Holland

ID# 0033969

Report Period Beginning: 06/01/03

Ending: 05/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (1,152)	21	1
2	Misc. Income	(9,730)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(10,882)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at South Holland # 0033969 **Report Period Beginning:** 06/01/03 **Ending:** 05/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(772)	0	0	0	0	0	0	0	0	0	0	(772)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(772)	0	0	0	0	0	0	0	0	0	0	(772)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(38,773)	0	0	0	0	0	0	0	0	0	0	(38,773)	19
20	Fees, Subscriptions & Promotions	(49,460)	0	0	0	0	0	0	0	0	0	0	(49,460)	20
21	Clerical & General Office Expenses	(92,803)	0	0	0	0	0	0	0	0	0	0	(92,803)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(181,036)	0	0	0	0	0	0	0	0	0	0	(181,036)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(181,808)	0	0	0	0	0	0	0	0	0	0	(181,808)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare at South Holland # 0033969 **Report Period Beginning:** 06/01/03 **Ending:** 05/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(181,808)	0	0	0	0	0	0	0	0	0	0	(181,808)	45

Facility Name & ID Number Manorcare at South Holland # 0033969 Report Period Beginning: 06/01/03 Ending: 05/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Manor Care, Inc.	100	Health Care & Retirement Corporation of America (See H.O. Cost Report)				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	$ 715,473	HCR Manor Care, Inc.	100.00%	$ 715,473	$	1
2	V	Page							2
3	V	8							3
4	V								4
5	V								5
6	V	10a	Theapy Management	35,086	Heartland Management Services	100.00%	35,086		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 750,559			$ 750,559	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Manorcare at South Holland # 0033969 Report Period Beginning: 06/01/03 Ending: 05/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Manorcare at South Holland # 0033969 Report Period Beginning: 06/01/03 Ending: 05/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR Manor Care, Inc.
Street Address: 333 North Summit St.
City / State / Zip Code: Toledo, OH 43604-2617
Phone Number: (419) 252-5500
Fax Number: (419) 254-5495

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,402,993,349	357 Nurs. Fac	$	$		$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,860,540,914	357 Nurs. Fac	940,169	509,589	10,579,818	3,477	2
3	5	Utilities - Direct	Accumulated Cost	2,402,993,349	357 Nurs. Fac	288,728		10,579,818	1,271	3
4	5	Utilities - Pooled	Accumulated Cost	2,860,540,914	357 Nurs. Fac	3,082,391		10,579,818	11,400	4
5	10	Nursing - Direct	Accumulated Cost	2,402,993,349	357 Nurs. Fac	11,758,547	7,451,541	10,579,818	51,770	5
6	10	Nursing - Pooled	Accumulated Cost	2,860,540,914	357 Nurs. Fac	6,213,378	3,630,889	10,579,818	22,980	6
7	17	General & Admin - Direct	Accumulated Cost	2,402,993,349	357 Nurs. Fac	17,137,345	15,146,077	10,579,818	75,452	7
8	17	General & Admin - Pooled	Accumulated Cost	2,860,540,914	357 Nurs. Fac	84,524,208	36,356,103	10,579,818	312,616	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,402,993,349	357 Nurs. Fac	4,283,731		10,579,818	18,860	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,860,540,914	357 Nurs. Fac	17,698,741		10,579,818	65,459	10
11	30	Depreciation - Direct	Accumulated Cost	2,402,993,349	357 Nurs. Fac	0		10,579,818	0	11
12	30	Depreciation - Pooled	Accumulated Cost	2,860,540,914	357 Nurs. Fac	12,354,014		10,579,818	45,693	12
13										13
14	32	Interest				11,412,188			106,495	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 169,693,440	$ 63,094,199		$ 715,473	25

Facility Name & ID Number Manorcare at South Holland # 0033969 Report Period Beginning: 06/01/03 Ending: 05/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Conv. Sub. Debentures		X	Facility			$ 1,399,326	$ 1,399,326		7.6104	$ 106,495	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8	Interest Income Other										(52)	8
9	TOTAL Facility Related						$ 1,399,326	$ 1,399,326			$ 106,443	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,399,326	$ 1,399,326			$ 106,443	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Manorcare at South Holland # 0033969 Report Period Beginning: 06/01/03 Ending: 05/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	518,246	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	558,954	2
3. Under or (over) accrual (line 2 minus line 1).	$	40,708	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	503,589	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	17,502	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	561,799	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	449,355	8
	2000	461,783	9
	2001	510,433	10
	2002	542,781	11
	2003	543,845	12

Line 2: $558,954 = $271,390 for 1st half of 2003 + $287,564 for 2nd half of 2002

Line 4: $503,589 = $272,455 for 2nd half of 2003 + $231,134 for Jan-May 2004

Line 5: $17,502 is the amount paid to Worsek & Vihon, P.C. for their successful 2002 Real Estate appeal.
The Cook County Assessor and Board of Review granted a reduction in the 2002 assessment.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare at South Holland COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0033969

CONTACT PERSON REGARDING THIS REPORT Gary Geise

TELEPHONE (419)252-5736 FAX #: (419)254-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	29-25-200-006-0000	See attached	$ 543,845.16	$ 543,845.16
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 543,845.16	$ 543,845.16

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Manorcare at South Holland # 0033969 Report Period Beginning: 06/01/03 Ending: 05/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,781 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1988	$ 929,902	1
2					2
3	TOTALS			$ 929,902	3

Facility Name & ID Number Manorcare at South Holland # 0033969 Report Period Beginning: 06/01/03 Ending: 05/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120			1988	$ 3,317,990	$ 154,331		$ 154,331	$	$ 2,095,241	4
5	60			1991	1,912,803						5
6	10			1997	1,054,638						6
7											7
8											8
	Improvement Type**										
9	Current Year Depreciation					138,401		138,401		1,356,806	9
10				1988	112,623						10
11				1989	36,052						11
12				1990	6,131						12
13				1991	255,298						13
14				1992	192,798						14
15				1993	108,676						15
16				1994	85,519						16
17				1995	50,587						17
18				1996	231,349						18
19				1997	120,584						19
20				1998	237,026						20
21				1999	8,872						21
22				2000	53,921						22
23	2 Doors			2001	3,999						23
24	Roof Inspection			2001	650						24
25	Drywall & Painting			2001	4,306						25
26	Drapes, Shades, Blinds			2001	3,068						26
27	Closet Doors & Drawer Fronts			2001	10,555						27
28	Painting, Wallcovering, Corner Guards			2001	48,553						28
29	Light Fixtures & Exit Signs			2001	5,292						29
30	Birch Doors & Shower Floors			2001	5,025						30
31	Carpet			2001	5,294						31
32	Garage 16x16			2001	14,687						32
33	Driveway for garage			2001	1,929						33
34	Birch Doors & Shower Floors			2002	4,644						34
35	Eletrical Work			2002	5,390						35
36	Paint, Wallcovering & Borders			2002	3,884						36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare at South Holland # 0033969 Report Period Beginning: 06/01/03 Ending: 05/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	General Construction	2002	$ 11,200	$		$	$	$	37
38	Floor Tile for Break Room	2002	2,794						38
39	Roofing	2003	12,928						39
40	Carpet	2003	382						40
41	Carpet/Flooring & Base	2003	18,216						41
42	Wallcovering & Border	2003	13,718						42
43	Renovation to Vending Machine Room	2003	5,794						43
44	Roofing	2003	1,010						44
45	Concrete	2003	2,050						45
46	Doors (2)	2003	3,033						46
47	Construction Dept. Cost & Interest	2003	5,152						47
48	Additional Electrical Outlets	2003	2,331						48
49	Fire Door	2004	1,463						49
50	Construction Dept. Cost & Interest	2004	985						50
51	Wallcovering & Border	2004	3,297						51
52	Doors	2004	2,284						52
53	Flooring	2004	3,807						53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,992,587	$ 292,732		$ 292,732	$	$ 3,452,047	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at South Holland # 0033969 Report Period Beginning: 06/01/03 Ending: 05/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,464,015	$ 152,193	$ 152,193	$		$ 1,030,186	71
72	Current Year Purchases	369,844						72
73	Fully Depreciated Assets							73
74				45,693	45,693			74
75	TOTALS	$ 1,833,859	$ 152,193	$ 197,886	$ 45,693		$ 1,030,186	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Residents	1995 Goshen GCH	1995	$ 17,000	$	$	$		$ 17,000	76
77		Paratransit								77
78										78
79										79
80	TOTALS			$ 17,000	$	$	$		$ 17,000	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,773,348	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 444,925	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 490,618	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 45,693	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,499,233	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 113,767 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elct. Beds, Etc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Manorcare at South Holland # 0033969 Report Period Beginning: 06/01/03 Ending: 05/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	6035 hrs	$ 172,951	7	$ 349	$ 4,742	6,042	$ 178,042	1
2	Licensed Speech and Language Development Therapist	10a	2924 hrs	81,808	165	8,630	1,492	3,089	91,930	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	5856 hrs	176,035	2,334	121,856	8,194	8,190	306,085	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescrpts				516,901		516,901	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab & X-ray	43, 3				136,012			136,012	13
14	TOTAL			$ 430,794	2,506	$ 266,847	$ 531,329	17,321	$ 1,228,970	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Manorcare at South Holland **#** 0033969 **Report Period Beginning:** 06/01/03 **Ending:** 05/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 05/31/04 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 107,522	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 352,690)	2,363,157		3
4	Supply Inventory (priced at)	8,135		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	25,842		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,504,656	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	929,902		13
14	Buildings, at Historical Cost	7,992,587		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,850,859		16
17	Accumulated Depreciation (book methods)	(4,499,233)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction in Progress			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 6,274,115	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,778,771	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 154,583	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	535,289		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	503,589		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	115,680		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,309,141	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	4,383		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,383	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,313,524	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 7,465,247	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,778,771	$	48

***(See instructions.)**

Facility Name & ID Number Manorcare at South Holland # 0033969 Report Period Beginning: 06/01/03 Ending: 05/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 6,792,285	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 6,792,285	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	2,785,385	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 2,785,385	17	
	B. Transfers (Itemize):			
18	**Change in Interdivision**	(2,112,423)	18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ (2,112,423)	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 7,465,247	24	*

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,705,027	1
2	Discounts and Allowances for all Levels	(3,269,876)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,435,151	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,844,024	6
7	Oxygen	4,089	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,848,113	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,152	12
13	Barber and Beauty Care	18,810	13
14	Non-Patient Meals	772	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	509,305	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	76,285	19
20	Radiology and X-Ray	49,771	20
21	Other Medical Services	135	21
22	Laundry	2,718	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 658,948	23
	D. Non-Operating Revenue		
24	Contributions	25	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 25	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income	9,730	28
28a	Late Charges	(1,031)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,699	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,950,936	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,332,218	31
32	Health Care	4,896,221	32
33	General Administration	2,892,745	33
	B. Capital Expense		
34	Ownership	1,120,439	34
	C. Ancillary Expense		
35	Special Cost Centers	819,618	35
36	Provider Participation Fee	104,310	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,165,551	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,785,385	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,785,385	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,049	2,198	$ 70,800	$ 32.21	1
2	Assistant Director of Nursing	4,127	4,427	127,930	28.90	2
3	Registered Nurses	31,337	33,615	792,169	23.57	3
4	Licensed Practical Nurses	52,149	55,940	963,855	17.23	4
5	Nurse Aides & Orderlies	138,515	148,584	1,305,320	8.79	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	14,521	15,486	459,427	29.67	7
8	Rehab/Therapy Aides	17,415	18,573	339,677	18.29	8
9	Activity Director	11,660	12,545	107,503	8.57	9
10	Activity Assistants					10
11	Social Service Workers	3,720	3,984	63,751	16.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	33,703	36,241	363,187	10.02	15
16	Dishwashers					16
17	Maintenance Workers	4,057	4,362	66,194	15.18	17
18	Housekeepers	20,913	22,482	180,397	8.02	18
19	Laundry	7,688	8,273	56,139	6.79	19
20	Administrator	2,080	2,080	93,348	44.88	20
21	Assistant Administrator	2,072	2,072	70,970	34.25	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	24,370	26,743	470,199	17.58	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,545	4,886	52,857	10.82	31
32	Other Health Care(specify)					32
33	Other(specify) Hospitalty					33
34	TOTAL (lines 1 - 33)	374,921	402,491	$ 5,583,723 *	$ 13.87	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	15,000	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,840	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 21,840		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	264	8,422	10, 3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	264	$ 8,422		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Tim Irwin	Administrator	0	$ 93,348
Katie Slench	Asst. Administrator	0	70,970
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 164,318

B. Administrative - Other

Description	Amount
Management Fees	$ 715,473
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 715,473

C. Professional Services

Vendor/Payee	Type	Amount
Foote, Meyers, Mielke, Flowers & So	Legal Fees	$ 38,773
Physicians Credit Bureau	Fees for collections	1,597
Christine Toolan, RHIA	Medical Records Consultant	771
Carol Gawron-Walters	Wound Care Consultant	24,651
Legal fees were adjusted off on Schedule VI, Page 5, Line 22. Therefore, no legal invoices are attached.		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 65,792

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 117,028
Unemployment Compensation Insurance	72,377
FICA Taxes	392,168
Employee Health Insurance	297,804
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreiation	9,619
401K	14,284
Other Employee Benefits	(1,323)
Tuition Program	307
SMSP Match	1,461
Employee Uniforms	2,848
Home Office Allocation	84,319
TOTAL (agree to Schedule V, line 22, col.8)	$ 990,892

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 6,443
Advertising: Employee Recruitment	51,029
Health Care Worker Background Check (Indicate # of checks performed 513)	9,789
Dues & Subscriptions	695
Association Dues	8,692
Advertising	39,277
Public Relations	7,504
Less Non-allowable Association Dues	(2,679)
Less: Public Relations Expense	(7,504)
Non-allowable advertising	(39,277)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 73,969

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	8,072
Includes travel expense to the Home Office in Toledo, OH for regional meetings	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,072

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Manorcare at South Holland # 0033969 Report Period Beginning: 06/01/03 Ending: 05/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
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14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Manorcare at South Holland # 0033969 **Report Period Beginning:** 06/01/03 **Ending:** 05/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $8692**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes $2679**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **98,829** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **104,310**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **772**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **No**
Attach invoices and a summary of services for all architect and appraisal fees.